Institute for Medical Quality

AMBULATORY ACCREDITATION

APPLICATION FOR ACCREDITATION SURVEY

INSTRUCTIONS

1) When completing this form, please type or print clearly. If there is insufficient space, you may add attachments. All attachments should be **clearly referenced**.

2) The *IMQ Accreditation Standards for Surgical and Outpatient Facilities* is a necessary guide for accreditation. You will be surveyed for compliance with all standards in the Manual. In addition to the standards, information about IMQ policies, legislation regarding ASC and outpatient surgery settings, and many other topics are in the manual's appendices.

3) **This application and the information contained herein are very important. We ask that special attention be paid to Section V: Attestations. These questions regarding malpractice judgments, accusations, actions pending, probations, restrictions, and other information for the facility and all professional and clinical staff (i.e., full time, part time, registry, and as needed) are critical. If this section contains incomplete or incorrect information, the accreditation process will be delayed, materials may be returned to you for re-submittal. Each question in Section V must be initialed by the owner or medical director.**

4) If this form is completed by someone other than the owner or medical director, it must be carefully reviewed and *signed* by the owner or medical director. This will ensure that the information is complete and accurate, which will simplify IMQ's processing of the application.

5) Please remember to include the non-refundable $975 application fee with this form. You will be invoiced for the survey fee. All fees must be paid at least a month before your on-site survey or one month from invoice date for **Medicare deemed status** surveys.

6) Please be sure that you retain a copy of all information submitted to IMQ, including a copy of this application and all the supporting documents.

7) **There are no provisions for extensions of a facility's expiration date.** Therefore, applications for re-surveys after a prior accreditation, including the completed application, requested materials, and application fee should be received by IMQ *four* months before the expiration date. This timeline ensures your survey is scheduled, completed, and accreditation approved prior to the expiration date. Nine-month re-surveys require only the updated application which should be received a *minimum of 90 days* before the expiration date.

Thank you for your participation in IMQ's Ambulatory Accreditation Program. Please contact Victoria Samper at 415-882-5173 or vsamper@imq.org if you have any questions.

INSTRUCTIONS

All of the following components **MUST** be submitted with this application. By collecting and reviewing documentation prior to the survey, IMQ is able to spend less time on-site. This allows for a less expensive survey. If you do not submit any of the documents listed below, please explain why they have not been submitted.

- Please divide and label each section by letter (a, b, c, etc.) as described below.
- **Do not use staples or plastic page savers.**
- Do not send originals, except for this application.
- Keep a copy of all materials submitted, including this application.
- Check off each item included in the application on the corresponding box below.
- Send original and one copy of ALL materials submitted (application and supporting documents listed below). For **Medicare deemed status surveys**, please send original and two copies. The copies should be a copy of the original (double-sided, three-holed punched).

		I. APPLICATION
☐	a)	The application fee ($975.00) is included with the application. An invoice for the survey fee will be sent upon receipt of the application
☐	b)	A detailed explanation for questions answered "Yes" in Section V (Attestations).
		II. FACILITY INFORMATION
☐	c)	Brief history of the facility. (A paragraph is adequate.)
☐	d)	Organizational chart of staff (showing reporting lines).
☐	e)	Sample of marketing materials (yellow pages ad, website homepage printout, brochures, patient handouts, videos, etc.)
☐	f)	Please provide one of the following three: Hospital transfer agreement with an accredited hospital within a reasonable transport distance, proof of the physician's admitting privileges in an accredited facility, or a written emergency plan. (Please refer to standards 6.3.9 and 7.9.1 for more information.)
☐	g)	Fire inspection certificate from your state/local authority, Certificate of Occupancy or Fire Inspection. **(Not for Medicare deemed status.)**
☐	h)	Clinical and Non-Clinical Staff job descriptions.
☐	i)	Statement of Patient rights and responsibilities.
☐	j)	Notice of Privacy Practices
		III. POLICIES AND PROCEDURES (Send **only** P&Ps which are relevant to the standards)
☐	k)	Administrative policies and procedures (Please **include documentation that addresses the following standards**: Chapter 1: Standards 1.1.4, 1.1.5, 1.2.2, and 1.3.3; Chapter 2: Standard 2.1.3; Chapter 5: Standards 5.4.1, 5.4.3, and 5.4.9; Chapter 6: Standards 6.3.1, 6.3.5 and 6.3.7).
☐	l)	Advance Directives Policy
☐	m)	Credentialing, privileging, and reappointment policies and procedures or Medical Staff Bylaws.
☐	n)	Quality Management (QM) plan/program.
☐	o)	Peer Review policies, procedures, and **sample** review form.
☐	p)	Infection control policies and procedures, including waste disposal.
☐	q)	Surgery, anesthesia, and recovery room policies and procedures.
		FOR MEDICARE DEEMED STATUS
☐	r)	Proof the 855B form has been processed by the carrier (for **Medicare deemed status** only)
☐	s)	Surgery/procedure schedule for future 3 months (for **Medicare deemed status** only)
☐	t)	Life Safety Code (LSC) Risk Assessment (for **Medicare deemed status** only)

Institute *for* Medical Quality

APPLICATION FOR ACCREDITATION SURVEY

Type of Survey: ☐ **Accreditation**
☐ **Medicare Deemed Status** **CCN #** _____

I. IDENTIFYING INFORMATION

Legal name of facility*:

** This must be the exact legal name as indicated on the facility's Articles of Incorporation. This will be the name indicated on the IMQ Accreditation Certificate.*

Alternate _____

Facility Address: _____

City, State, Zip: _____

County: _____

Phone number: ( ) - ←***This must be the main phone # at the facility.***

Fax number: ( ) - ←***This must be the main fax # at the facility.***

Email address: _____ **Website** _____

*** Include all alternate names of your facility such as "dba's" (doing business as) or names commonly used by the public.*

Individual Responsible for facility
(CEO, Sole Physician, etc): _____ Title: _____
EXAMPLE: CEO, MEDICAL DIRECTOR

Your facility will need to **designate an INTERNAL contact person**. This individual will be the contact for IMQ correspondence and communications related to the application, scheduling, invoicing, and post survey activities.

Contact person:_____ Title:_____

E-mail: _____ Phone (required):_____

If the facility is using a consultant, **also** please include: Name: _____

E-mail: _____ Phone (required):_____

FACILITY TYPE (select one only):

☐ Ambulatory Surgery Center
☐ Diagnostic Imaging Center
☐ In-vitro Fertilization Center
☐ Medical Group Practice
☐ Office-based Surgery Center
☐ Endoscopy Center
Other_____

FACILITY SPECIALTY (select all that apply):

☐ Cardiology
☐ Cosmetic Surgery
☐ Derm/Derm Surgery
☐ Dental Practice
☐ Emergency Medicine
☐ Facial, Plastic/Recon.
☐ Family Practice
☐ Fertility
☐ Foot and Ankle Surgery
☐ Gastroenterology
☐ Internal Medicine
☐ IVF
☐ OB/GYN
☐ Occupational Medicine
☐ Ophthalmology
☐ Oral/Maxillofacial Surg.
☐ Orthopedics
☐ Otolaryngology
☐ Pain Management
☐ Pediatrics
☐ Preventive Medicine
☐ Radiation Oncology
☐ Sports Medicine
☐ Urgent Care
☐ Urology
☐ Other_____

Is your facility planning on adding additional specialties that are not currently listed above?

☐ Yes ☐ No If yes, please list: _____

II. FACILITY PROFILE

1) Please indicate ownership structure: ☐ Professional Corporation ☐ Partnership Other:_____

2) Please list the name(s) of your facility's owner(s), type of practitioner, license number, and percentage of ownership.

Name/Address	Phone Number	Type of Practitioner (MD, DO, DPM etc.)	Medical License	Percentage of Ownership

3) Does your facility have any satellite offices, or is your facility owned, operated, managed, or affiliated with another organization? ☐ Yes ☐ No

(If yes, please attach a list of the names of ALL such entities including: a) Name of facility b) Address c) Relation to your organization d) If the entity is seeking IMQ accreditation.)

4) Please indicate all licenses and accreditations that apply to your facility (i.e., not for practitioners).

	Never	Previously	Currently	Expiration Date (mm/dd/yy)	License or Certification #
If your state requires: Licensed by the Dept of Public Health					
Certified by Medicare - if Medicare deemed status, please enter the name of the AO under Other*					
IMQ Accredited					
Joint Commission Accredited					If yes, attach copy of last report
AAAHC Accredited					If yes, attach copy of last report
AAAASF Accredited					If yes, attach copy of last report
Other *_____					If yes, attach copy of last report

5) At this time, is your facility operational (including the possession of applicable building/business permits), equipped (including all necessary medical and emergency equipment) and staffed to provide all of the services/procedures indicated in this application? ☐ Yes ☐ No (If no, please provide detailed explanation.)

_____

_____

_____

6) Our facility was founded (at the current location with the current ownership/staff) in: _____.

7) Our facility began providing health care services to patients on this date (month/year):_____ (The type of procedures is irrelevant. If the facility has not yet opened, please indicate anticipated opening date.)

8) Our facility utilizes:
_____ number of operating rooms
_____ number of recovery beds

9) Our facility:

Days and hours of surgery: _____

Days and hours of operation are: _____

Does approximately _____ procedures per month

Provides overnight care or refers to overnight care:..... ☐ Yes ☐ No

Provides services to children under age 16:..... ☐ Yes ☐ No

Utilizes X-ray equipment:…..... ☐ Yes ☐ No

Utilizes laser technology: ..... ☐ Yes ☐ No

Has on-site individual credential files for <u>all</u> doctors, nurses, and other clinical personnel: ☐ Yes ☐ No

Utilizes ☐ Paper copy medical records ☐ Electronic medical records: _____
Indicate name of EMR software here

Utilizes: ☐ Internal billing staff ☐ External billing company: _____
Indicate name of company here

10) Facilities with less than 10 physicians should follow the SSG (small or solo group) standards, while facilities with 10 or more physicians should follow the OMS (Organized Medical Staff) standards. (Please note that physicians, surgeons, and anesthesiologists that are used only occasionally should be counted for this determination).

Our facility falls under the: ☐ SSG Model ☐ OMS Model How many physicians practice at this facility? _____

11) Please indicate the type of peer review your facility utilizes:

☐ External peer review (Mandated for facilities with less than 3 physicians of the same or SIMILAR clinical privileges.)

☐ Internal peer review (Customary for facilities with 3 or more physicians of the same OR SIMILAR privileges, OR IF THE FACILITY UTILIZES AN APPROVED MECHANISM TO ACHIEVE PEER REVIEW MEETING THE SAME INDICATIONS IDENTIFIED IN THE STANDARD.)

12) If you utilize <u>external</u> peer review, please complete the chart below. (Peer review is defined as another physician of the same or SIMILAR clinical privileges or CRNA who does periodic evaluations of your practice and competence.)

Staff Physician/CRNA Name	Type (MD, DO, CRNA)	Specialty	Name of Peer Reviewer	Type (MD, DO, CRNA)	Specialty

13) Please indicate, by type of license (Ex: MD, CRNA, RN, LVN, etc.), who administers the medication for procedures with:

Local/topical anesthesia: _____

Regional anesthesia:_____

Minimal Sedation:_____

Moderate sedation (conscious sedation):_____

Deep sedation/anesthesia:_____

General anesthesia:_____

14) Why is your facility interested in seeking accreditation? Please check all that apply.

- ☐ Compliance with state law and/or CMS (Medicare) conditions for coverage.
- ☐ To obtain education and consultation regarding standards of care.
- ☐ To demonstrate to the public your facility's dedication to high standards of care.
- ☐ HMO or other third-party payer recognition/reimbursement.
- ☐ Other_____

15) Please check the month(s) and day(s) of the week that you would like your on-site survey to occur. Submit this application *4 months* in advance of your anticipated survey date (for *new* facilities) OR *4 months* in advance of your *expiration* date (for *accredited* facilities). IMQ staff will coordinate with your facility to confirm a specific date within the month indicated, **except for Medicare deemed status surveys because they MUST be unannounced**. *A late application fee will apply to applications not postmarked 3 months before your facility's expiration date.* **There is no provision for extension of a facility's expiration date.**

FACILITIES REQUESTING MEDICARE DEEMED STATUS SURVEY:

Medicare requires surveys to be unannounced. Therefore, facility must SUBMIT THE SURGERY SCHEDULE FOR 90 DAYS FOLLOWING THE APPLICATION DATE.

A Medicare deemed status survey MUST INCLUDE the observation of a procedure/surgical case. If there are changes to the schedule, IMQ must be informed, IMMEDIATELY. The facility understands that if a procedure/surgical case cannot be observed, the surveyor will need to return to complete the survey on another day. A "return to complete survey" fee will apply.

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
☐	☐	☐	☐	☐	☐

The nearest airport to our facility is _____, which is approximately _____ miles away.

Names of two moderately (mid range) priced hotels near your facility with easy access to restaurants:

Name _____
Address_____
City, St, Zip_____
Telephone ( ) _____
Distance from your facility _____

Name _____
Address _____
City, St, Zip _____
Telephone ( ) _____
Distance from your facility _____

III. FACILITY STAFFING AND PROCEDURES PERFORMED

16) Please list below the names of all clinical personnel rendering any type of clinical health care service in your facility. This would include all physicians, nurses, operating room technicians, etc; whether they are employees or contract staff. (Question #17 is for non-clinical personnel.) **Not applicable to OMS with 10 or more clinicians.**

Key: E=Employee, C=Contractor, FT=Full Time, PT=Part Time, AN=As needed (not routinely used)

Full Name EX: JOHN SMITH	**Degree** MD, RN, etc.	**License Number**	**Specialty** EX: DERMATOLOGY	**Title** EXAMPLE: OR SUPERVISOR, RECOVERY ROOM NURSE, SCRUB TECH	**E or C**	**FT, PT, AN**	**How long on staff?**

17) Please list below the names of all administrative (non-clinical) personnel in your facility. This would include administrators, receptionists, file clerks, etc; whether they are employees or contract staff. Not applicable to OMS with 10 or more non-clinical staff.

Key: FT=Full Time, PT=Part Time, AN=As needed (not routinely used)

Full Name EX: TOM JONES	**Title** EXAMPLE: RECEPTIONIST, OFFICE MANAGER, BILLING SUPERVISOR	**FT, PT, AN**	**How long on staff?**

18) Please submit a list of all procedures performed under local/topical, oral, or minimal sedation by your facility. This list should be submitted as a separate attachment, must be all inclusive, and signed by the owner/Medical Director. If there are procedures that you do not offer now, but plan to offer in the future, please include them on this list and label accordingly.

19) Please submit a list of all procedures performed under conscious sedation, regional anesthesia, deep sedation/anesthesia, or general anesthesia by your facility. This list must be all inclusive, should be completed in the chart below, and signed by the owner/Medical Director. (Please copy this page if you need additional lines.)

Key:

Procedure/Service:	*The name of the procedure or service.*
Type of Anesthesia:	*The type of anesthesia used. Please indicate L for local/topical, M for minimal sedation, CS for conscious sedation, R for regional anesthesia, D for deep sedation/anesthesia, and G for general anesthesia.*
Anesthesia Provider	*Type of provider administering the anesthesia. Ex: MD, CRNA.*
Type of Support Staff:	*Type of support staff assisting on these procedures. Ex: NP, RN, LVN, Scrub tech.*
Date began offering procedure:	*The date your facility first began offering this procedure. If you do not currently offer the procedure, but plan to offer it in the future, please indicate "F".*
Number performed per year:	*The approximate number performed monthly. If your facility currently does not offer the procedure, please estimate the approximate number.*

Procedure/Service	Type of Anesthesia	Anesthesia provider MD/CRNA	Type of support staff	Date began offering this procedure	Number performed per month

Signature of Owner
or Medical Director: _____ Date: _____

Print Name: _____ Title:_____

IV. ATTESTATIONS

Please answer the following questions and have your organization's Medical Director initial each answer. This section pertains to all professional and clinical staff rendering services at your facility (i.e. full time, part time, registry, and as needed.) For any "yes" response, please provide a *full and detailed* explanation as a separate attachment.

20. ☐ Yes ☐ No
INITIAL

Medicare, Medicaid, and other public programs: **Within the last 4 years**, has your facility, or any health care provider in your facility, been suspended, fined, disciplined, sanctioned, restricted, or excluded for reasons relating to possible incompetence or improper professional conduct, by Medicare, Medicaid, or any public program, or is any such action pending?

21. ☐ Yes ☐ No
INITIAL

State license: **Within the last 4 years**, is there any physician or other licensed health care provider in your facility whose state medical license, or any U.S. state or territory (Medical Board, Osteopathic Medical Board, Board of Registered Nursing, etc.) has been denied, limited, suspended, revoked, not renewed, or subject to probationary conditions, or has been fined or received a letter of reprimand, or accusation, or is such action pending? (Note: This includes accusations.)

22. ☐ Yes ☐ No
INITIAL

Lawsuits, judgments and settlements: Have any judgments been entered against your organization or any health care provider in your organization, or settlements been agreed to by your organization or any health care provider in your organization **within the last four (4) years**, in professional liability cases, or are there any filed and served professional liability lawsuits/arbitrations against your organization or any health care provider in your organization pending?

23. ☐ Yes ☐ No
INITIAL

DEA and pharmaceutical permit: **Within the last 4 years**, is there any health care provider in your facility whose Drug Enforcement Administration (DEA) registration or an applicable narcotic registration in any jurisdiction has been denied, limited, suspended, revoked, not renewed, or subject to probationary conditions, or has been fined or received a letter of reprimand, or is such action pending?

24. ☐ Yes ☐ No
INITIAL

Clinical privileges, membership, and employment: **Within the last 4 years**, has your facility, or any health care provider in your facility been denied, for possible incompetence or improper professional conduct, clinical privileges, membership, contractual participation/employment by any medical organizations (e.g., hospital, medical group, independent practice association, HMO, PPO, private payer [and those that contract with public programs], medical society, professional association, medical school faculty position or other health delivery entity or system) or have clinical privileges, membership, participation or employment at any such organization been suspended, restricted, revoked or not renewed, or is any such action pending?

25. ☐ Yes ☐ No
INITIAL

Professional organizations: **Within the last 4 years**, has your facility, or any health care provider in your facility had membership or fellowship in any local, county, state, regional, national, or international professional organization revoked, denied, suspended, limited, not renewed, subject to probationary conditions, or received a letter of reprimand, or is any such action pending?

26. ☐ Yes ☐ No
INITIAL

Board certification: **Within the last 4 years**, is there any health care provider in your facility whose certification or re-certification by a specialty board has been denied, limited, suspended, revoked, not renewed, or subject to probationary conditions, or received a letter of reprimand, or has had an eligibility status change, or is such action pending?

27. ☐ Yes ☐ No
INITIAL

Unfair labor practice or other adverse administrative actions: **Within the last 4 years**, has your organization, or any employee or agent of your organization, been found guilty of any unfair labor practice or suffered any other adverse administrative arbitration or court finding involving the operation of the organization, or is such action pending?

28. ☐ Yes ☐ No
INITIAL

Professional liability insurance: **Within the last 4 years**, has your organization's professional liability insurance, or the professional liability insurance of any health care provider in your organization been denied, terminated, not renewed, restricted, or modified (e.g., reduced limits, restricted coverage, surcharged), or has any professional liability carrier provided your organization or any health care provider in your organization with any notice of intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures?

V. CONSENT

By making this application to IMQ for an accreditation survey or accreditation with Medicare deemed status survey of the organization named in Section I, the undersigned acknowledges, affirms, and consents to all of the following:

1. All information contained in this application and in any type of communications with IMQ, is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. The organization understands that providing falsified information may be grounds for denial of eligibility for an IMQ survey. It may also be grounds for denial, suspension, or revocation of an organization's accreditation and/or whereby IMQ may cease doing business with the organization.

2. The accreditation survey will be conducted by one or more IMQ surveyors, selected by IMQ, and will include the inspection of records and documents, including but not limited to patient charts and medical staff records. I agree to provide the information requested by IMQ for the survey and to participate fully, honestly, and in good faith in the survey process.

3. The accreditation survey will apply to the organization's entire practice. IMQ will limit its review to a sub-part(s) of the organization only if that sub-part(s) constitutes a separate legal entity.

4. The state licensing agency and any other relevant examining or reviewing body may release any information concerning the organization to IMQ as necessary for consideration concerning accreditation.

5. IMQ may publicly release the organization's accreditation status if the organization attains accreditation. IMQ is required by law to release the organization's accreditation status and any pertinent documents to some state Medical Boards, regardless of the organization's accreditation status. The Medical Board must notify the public upon inquiry whether a setting is accredited, certified, or licensed, and whether the setting's accreditation, certification, or license has been revoked. IMQ acknowledges that all information obtained in the accreditation survey process is considered confidential between IMQ and the survey organization, except as provided above and as otherwise required by law, and that it will maintain the confidentiality of that information to the fullest extent permitted by law.

6. If the organization receives accreditation, the organization is responsible for maintaining compliance with IMQ accreditation standards for the full duration of the accreditation term. The organization agrees to notify IMQ prior to any material change in name, ownership or control, or not more than 30 days after any other major change in organization, facilities, capacity, categories or scope of services offered, or location. IMQ has the option of an announced survey for **Medicare deemed status surveys** or if concerns are raised about continued compliance with accreditation standards. The organization understands that failure to maintain compliance with IMQ accreditation standards or to notify IMQ of changes noted above can result in loss of accreditation. The facility will be charged for an announced survey.

7. It is understood that accreditation does not constitute a warranty of compliance with the standards of accreditation and, further, that it is not a substitute for on-going self-monitoring and assessment of the services and the quality of care provided by the organization. The applicant organization agrees to indemnify and hold harmless IMQ, its directors, officers, employees, and agents from any and all claims of any kind against IMQ, its directors, officers, employees and agents, including all judgments, settlements, costs, expenses and attorneys' fees that arise in connection with or as a result of IMQ's survey of the applicant, or accreditation decision, unless and until any judgments, settlements, costs, expenses, and attorneys' fees are found by a final judgment of a court of competent jurisdiction to have resulted primarily from negligence or wrongdoing on the part of IMQ.

8. The applicant organization understands and agrees that in the event of any error or omission in connection with or as a result of the performance of accreditation services including, but not limited to, the scheduling and conduct of any accreditation survey, the processing of any accreditation survey, the accreditation decision, and the disclosure of any accreditation survey results, IMQ's liability for any loss or damage shall be limited to the fees payable for the accreditation survey conducted hereunder. This limitation of liability shall apply to the full extent permitted by law, regardless of whether the applicant organization's claim for loss or damage is based upon contract, tort, strict liability or otherwise, and shall constitute IMQ's sole liability to the applicant organization and the applicant organization's exclusive remedy against IMQ in the event of such error or omission. IMQ shall not be liable for any consequential or exemplary damages, even if advised in advance with respect thereto. The applicant organization specifically waives any right to any such claim for loss or damage.

9. The parties shall attempt to resolve any controversial claim arising out of or relating to this agreement, or the breach thereof, in an amicable way. Failing this, any remaining controversy or dispute in connection with agreement shall be settled by arbitration in San Francisco, California. Matters within jurisdiction of the Small Claims Court are excluded from this section. Such arbitration shall be governed by the California Code of Civil Procedure provisions related to arbitration. The award in any such arbitration shall be final. The judgment thereon may be entered in any court of competent jurisdiction.

10. The person executing this agreement expressly represents and warrants that he or she has the authority to execute this agreement on behalf of the organization, and that upon execution, the organization and its directors, officers, employees, and agents shall be bound by each and every term hereof.

11. The organization meets IMQ survey eligibility requirements as stated below:
    1. The facility is in compliance with applicable laws and regulations.
    2. The facility is licensed by the state if required by law.
    3. The facility is a formally organized and legally constituted entity, or a subunit of such an entity, that primarily provides health care services.
    4. The facility provides medical care that is under the direction of a physician (or group of physicians) who accepts responsibility for that care.
    5. The facility provides the signed Application for Accreditation Survey and all other required documents prior to the on-site review.
    6. The facility pays the appropriate application and survey fees at least one month before your on-site survey or, for Medicare deemed status surveys, within a month of invoice date.

Signature of Owner
or Medical Director: _____ Date: _____

Print Name: _____ Title:_____

****The signer above agrees to all stipulations in this document and agrees to contact IMQ in writing immediately upon any changes****

You have now completed IMQ's Application for Accreditation Survey. Before you mail in this form, please remember to:

- *Include the $975 Application Fee (non-refundable) payable to IMQ.*
- *Include all supporting documents listed under the Instructions section, (paper-clipped rather than stapled).*
- *Include two sets of ALL materials submitted (your application and all supporting documents).* ***FOR CMS SURVEYS PLEASE INCLUDE THREE SETS****.*
- *The Medical Director must initial all items in Section IV, page 70.*
- *For any item checked "YES" in Section IV, include a full and detailed explanation (who, what, where, why, when). Also, include complete copies of official and/or legal documents pertaining to the matter.*
- *The Medical Director must review and approve all items in this application, and sign page 9****.***
- *Keep a copy of all materials submitted, including the application, for your records.*

PLEASE MAIL ALL IMQ MATERIALS TO:

Regular Mail/FedEx/UPS
Ambulatory Accreditation Program
Institute for Medical Quality
180 Howard Street, Suite 210
San Francisco, CA 94105

THANK YOU